United States Department of Labor
Employees' Compensation Appeals Board

C.T., Appellant	)	
and	)	**Docket No. 14-1419**
	)	**Issued: January 26, 2015**
DEPARTMENT OF THE NAVY, OFFICE OF NAVAL PERSONNEL, Millington, TN, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 10, 2014 appellant, through her attorney, filed a timely appeal from a January 16, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant met her burden of proof to establish bilateral upper arm conditions causally related to factors of her employment.

FACTUAL HISTORY

On April 15, 2013 appellant, then a 47-year-old American sign language (ASL) interpreter, filed an occupational disease claim alleging that she developed bilateral shoulder and

[1] 5 U.S.C. § 8101 *et seq.*

elbow conditions as a result of the way she held her shoulders and hands and the amount of interpreting she did in the performance of duty. She first became aware of her conditions on November 1, 2009 and realized it resulted from her employment on December 1, 2009. Ralph E. Decker, appellant's supervisor, noted that for the time period that appellant worked directly for him he was unsure as to what nature of her work would have caused her illness.

The record reveals that appellant has a history of upper extremity problems. About 18 years ago she fractured her left ulnar and underwent surgery to move her extensor capri ulnaris and a synthetic sheath was implanted. From April 2010 to January 2013, appellant underwent various other surgeries to her upper extremities, including two right shoulder surgeries, left tarsal tunnel and left wrist surgery, right tarsal tunnel, and elbow surgery, in addition to lower extremity surgeries for right and left foot tarsal and plantar fasciitis.[2] She was on and off duty while recovering from her most recent surgery. In September 2012, appellant returned to light duty. On January 29, 2013 she stopped work again and did not return.

In an undated letter, appellant reported that she was the sole interpreter for six deaf or hard of hearing employees. She stated that in approximately November 2009 she began to experience pain and fatigue going down her right shoulder and was unable to hold her arms up for an extended period of time without experiencing severe discomfort. Appellant described the medical treatment she received, which included steroid injections, physical therapy, and multiple surgeries. She stated that her physician informed her that this type of injury was typically seen in people who constantly have their arms at shoulder height or higher for extended periods of time. Appellant believed that the employment-related activities that contributed to her condition were the requirement to facilitate daily sign language communication for six deaf and hard of hearing individuals in their work environment, logging and journaling her interpreting activities, and other jobs as assigned by her supervisor. She noted that these activities were performed daily for varying amounts of time from 30 minutes to 2 hours depending on the situation. Appellant reported that she also worked part time as a trilingual video interpreter where she worked less than 20 hours a week and had a 10-minute break every 50 minutes.

In a December 30, 2009 report, Dr. Christopher M. Pokabla, a Board-certified orthopedic surgeon, noted appellant's complaints of right shoulder pain and symptoms that began about a year ago. He reported that she believed her work as a sign language interpreter contributed to her symptoms. Dr. Pokabla reviewed appellant's history and conducted an examination of her right shoulder. He observed decreased internal rotation when compared to the contralateral side and minor tenderness over the biceps tendon anteriorly. Strength testing was five out of five. Neer's test was positive indicating impingement. Dr. Pokabla diagnosed right shoulder rotator cuff tendinitis/impingement. He noted that appellant had the "head forward type posture," which

[2] On April 7, 2010 appellant underwent right shoulder arthroscopic surgery with rotator cuff repair, subacromial decompression, and distal clavicle excision. On December 17, 2010 she underwent left foot tarsal tunnel release and left peroneal exploration, repair, and tenodesis. On October 17, 2011 appellant underwent left wrist decompression with tenosynovectomy and dorsal stabilization. On January 3, 2012 she underwent right foot tarsal tunnel release and endoscopic plantar fascia release. On June 21, 2012 appellant underwent another right shoulder arthroscopic surgery with rotator cuff repair and revision. On July 13, 2012 she underwent right elbow lateral release. On January 29, 2013 appellant underwent right elbow arthroscopy with synovectomy and debridement. On January 30, 2013 she underwent right shoulder arthroscopic surgery with biceps tenodesis.

he opined was "due to the fact that she [was] doing a lot of interpreting and therefore [was] having her posture pulled forward." Dr. Pokabla recommended physical therapy two to three times a week and advised them to work on rotator cuff strengthening and to get her head back.

In a January 27, 2010 report, Dr. Jay Dudley, Board-certified in family and preventative medicine, stated that appellant was examined for follow-up of rotator cuff tendinitis and impingement. Upon examination, he observed pain and about 4+/5 with supraspinatus isolation testing. Strength testing of appellant's supraspinatus had an interval worsening. O'Brien test was grossly positive. Dr. Dudley diagnosed rotator cuff tendinitis and impingement. He recommended a magnetic resonance imaging (MRI) scan to rule out a rotator cuff tear.

Dr. Pamela H. Burdett, a Board-certified diagnostic radiologist, reviewed the February 1, 2010 MRI scan of the right shoulder and noted thinning and fraying of the articular surface and supraspinatus tendon. She also observed a small linear partial thickness articular surface tear at the mid substance of the tendon. Dr. Burdett diagnosed moderate supraspinatus tendinopathy with thinning and articular surface fraying and tiny linear partial-thickness articular surface tear, mild-to-moderate infraspinatus tendinopathy without tear, mild acromioclavicular joint arthropathy with moderate degenerative changes of the distal clavicle, and minimal subacromial bursitis.

Appellant submitted various reports by Dr. John J. Lochemes, a Board-certified orthopedic surgeon, dated September 14, 2010 to April 20, 2012, for treatment for her foot and ankle conditions. Dr. Lochemes noted that she underwent several surgeries, including bilateral cubital tunnel decompressions on the right side, three carpal tunnel releases on the right, two on the left, and a tarsal tunnel release of the left foot.

Appellant continued to receive medical treatment from Dr. Pokabla for right shoulder pain from February 3, 2010 to March 20, 2013. In a February 3, 2010 report, Dr. Pokabla related her complaints of persistent right shoulder pain, rotator cuff tendinitis, and impingement and noted that a February 1, 2010 MRI scan of the right shoulder revealed partial thickness rotator cuff tear and impingement. In May 5 and 24, 2010 reports, he related that appellant's right arm and shoulder were sore due to using her arm to sign for deaf people. Dr. Pokabla also noted that appellant felt a "pop" in her shoulder during physical therapy and that she experienced pain after interpreting for one and one half hours. In January 24 and February 18, 2011 reports, he related that appellant had undergone right shoulder rotator cuff repair surgery in April 2010 but still complained of sharp, intermittent pain with certain movements and weakness. Dr. Pokabla stated that they discussed the stresses her job as a sign language interpreter placed on her shoulder. He reported that appellant worked up to "10 hours a day with her shoulder in an elevated position." Dr. Pokabla explained that her job-related activities were not giving her shoulder any time to rest and put unusual strain on her shoulder. In an August 31, 2012 report, he stated that "[appellant's] occupation as a signer for the deaf certainly put her shoulder at increased stress." In an August 31, 2012 report, Dr. Pokabla noted that she continued to complain of pain anterior in the left shoulder and diagnosed left shoulder rotator cuff syndrome.

In a September 21, 2012 report, Dr. Pokabla related appellant's complaints of consistent bilateral shoulder pain anteriorly and her concerns about disability with signing at work. Examination revealed tenderness anteriorly around the area of the coracoid and the pec minor

insertion. Dr. Pokabla advised appellant to return to light duty on September 24, 2012. Appellant was limited to signing and interpreting for 5 to 10 minutes at a time with support services as needed, frequent resting of the right upper extremity, and limited repetitive motions. Dr. Pokabla diagnosed status post revision rotator cuff repair and continued anterior shoulder pain. He indicated that appellant needed to work with restrictions as signing required her to keep her arms elevated above her head for long periods of time. In an October 3, 2012 report, Dr. Pokabla stated that she should continue working light duty.

In a March 20, 2013 report, Dr. Pokabla stated that appellant was postrevision rotator cuff repair and was doing better. Examination revealed range of motion 150/35/buttock and no evidence of a Popeye deformity. Strength was almost five out of five for supraspinatus with only minimal substitution. Dr. Pokabla diagnosed status post revision rotator cuff repair and status post biceps tenodesis.

Appellant also submitted various reports dated August 24, 2011 to March 6, 2013 by Dr. Christian Fahey, a Board-certified orthopedic surgeon, for complaints of elbow pain. In August 24 to September 19, 2011 reports, Dr. Fahey related that appellant was a right-hand dominant sign language interpreter who had multiple operations on her upper extremities. He noted her complaints that the pain and swelling in her wrist had progressively worsened. Dr. Fahey provided examination findings and diagnosed hand and wrist tenosynovitis. In a December 12, 2011 report, he noted that appellant had left wrist surgery about two months ago. Dr. Fahey authorized her to return to full duty on December 23, 2011 and remain in a brace. In reports dated June 13 to December 12, 2012, he noted appellant's complaints of progressively worsening pain of both hands and elbows. Upon examination, Dr. Fahey observed that appellant was very tender on the epicondyle and had diffuse Tinel's sign. He diagnosed bilateral lateral epicondylitis. In a March 6, 2013 report, Dr. Fahey noted that appellant was examined for postoperative follow-up of right elbow arthroscopy with synovectomy. Upon examination of her elbow, he observed that appellant's elbow was no longer swollen and she had full flexion, pronation, and supination. Dr. Fahey reported that appellant was doing better.

In a May 24, 2012 right shoulder arthrogram and MRI scan, Dr. Robert A. Duke, a Board-certified diagnostic radiologist, noted appellant's history of right shoulder pain and previous shoulder surgery. He reported that arthrogram images showed satisfactory opacification of the joint capsule and no extra-articular extravasation of contrast material. Dr. Duke also stated that MRI scan images revealed a focal elongated defect in the greater tuberosity consistent with a single bone anchor. He also noted a Type 1 acromion process. Dr. Duke diagnosed status post rotator cuff repair with bone anchor within greater tuberosity as noted and subacromial subdeltoid bursa effusion consistent with bursitis.

In a September 25, 2012 MRI scan of the right elbow, Dr. Donald D. Owens, a Board-certified diagnostic radiologist, noted that appellant underwent elbow surgery in 2012. He observed intact extensor tendon, ulnar, and radial collateral ligaments. No tendon abnormalities or demonstrable mass was identified. Dr. Owens diagnosed postoperative change regional to the site of origin of the common extensor tendon and otherwise negative MRI scan of the right elbow.

By letter dated April 17, 2013, OWCP advised appellant that the evidence submitted was insufficient to establish her claim. It requested that she respond to specific questions regarding the employment-related activities that she believed contributed to her condition and to submit medical evidence to establish that she sustained a diagnosed condition as a result of her duties as an ASL interpreter. In a similar letter to the employing establishment, OWCP requested additional information from a knowledgeable supervisor regarding the type of repetitive tasks that appellant performed at work.

In various reports dated January 11 to May 28, 2013, Dr. Kenneth Weiss, a Board-certified orthopedic surgeon, examined appellant for status post right shoulder arthroscopy with arthroscopic biceps tenodesis and left subacromial injection and injection of her bicipital groove. He related that she was moving her arm and felt a pop in the shoulder. In a March 28, 2013 report, Dr. Weiss related appellant's complaints of continued left shoulder and some right shoulder pain. Upon examination, he observed no signs or symptoms of infection from appellant's wounds. Dr. Weiss provided range of motion findings and noted 4/5 motor strength. Supraspinatus stress and isolation tests were both negative. Dr. Weiss diagnosed status post right shoulder arthroscopy with biceps tenodesis. He stated that, due to the fact that appellant signed for a living, he did not think that she could return to such work at this point due to the repetitive use of the arms. In a May 28, 2013 report, Dr. Weiss explained that he felt that what appellant was doing with her "repetitive use and work at shoulder level [had] aggravated or at least contributed to her shoulder condition that required surgery." He stated that she was authorized to return to light duty with restrictions of no overhead/repetitive use of the right upper extremity and no pushing, pulling, or lifting greater than two pounds. Dr. Weiss hoped to allow appellant to return to full duty in the next two to four months. He provided return to work notes dated April 30 and May 28, 2013 with these restrictions.

In a May 8, 2013 statement, appellant related that in November 2009 she began to experience pain and fatigue going down her right shoulder and was unable to hold her arm up for the extended period of time needed to interpret without experiencing severe discomfort. She described the medical treatment she received, which included a second right shoulder surgery in June 2012 and elbow surgery in July 2012. Appellant reported that she was off work for three months and returned to light duty with limited signing/interpreting. She alleged that Command rarely adhered to her restrictions when she interpreted a function, which contributed to her need for a third right shoulder surgery and a second right elbow surgery in January 2013. Appellant explained that she was the sole sign language interpreter for the employing establishment with no relief interpreter. She reported that she was required to interpret various classes such as job training, evaluations, or Command sponsored events that may last up to six hours without relief. Appellant noted that industry standard required two interpreters when interpreting continuously for longer than 50 minutes.

In a May 16, 2013 e-mail, Mr. Diecker, a workforce development manager, stated that he could neither confirm nor deny that appellant's current medical conditions were a result of work while assigned under his supervision. He stated that he was aware that she was accomplishing sign language duties after normal hours and with another employer.

In a June 3, 2013 letter, Antoinette B. Brady, Director of the Equal Employment Opportunity and Diversity Management Program (EEODM), stated that she did not have first-

hand knowledge of appellant's daily activities prior to her joining the EEODM staff in December 2011. She reported that appellant's tasks involved sign language interpretation and keyboarding, which required repetitive shoulder, arm, hand, and wrist movements. Ms. Brady noted that appellant performed these tasks daily for about eight hours, two days a week and seven hours, three days a week. She explained that for sign language interpretation she advised appellant to follow the professional standard, which included a break of at least 15 minutes for each hour of interpretation and more frequent breaks when the material being interpreted was highly technical. Ms. Brady also provided various performance appraisals and e-mails from appellant regarding missing work for medical reasons.

In a decision dated June 19, 2013, OWCP denied appellant's occupational disease claim. It accepted that she worked as an ASL interpreter and was diagnosed with various shoulder and elbow conditions but denied her claim finding insufficient medical evidence to establish that her diagnosed conditions were causally related to factors of her employment.

By letter dated July 17, 2013 and received on July 23, 2013, appellant requested a review of the written record. She contended that Drs. Pokabla and Weiss established a causal relationship between her job and her injuries. Appellant stated that the position descriptions of her interpreter positions demonstrated the physical demands of being a sole interpreter. She also pointed out that she had to meet the requirements to maintain national certification for her job. In a letter dated July 23, 2013, appellant withdrew her request for a review of the written record and requested reconsideration.

In a July 5, 2013 report, Dr. Pokabla stated that he initially examined appellant on December 30, 2009 and diagnosed rotator cuff tendinitis. He noted that at that time she worked as a sign language interpreter, which involved a "significant amount of time with her shoulder in a forward flexion position holding her arm approximately at shoulder height." Dr. Pokabla reviewed the medical treatment appellant received and noted that she underwent various surgeries, injections, and physical therapy. He opined that appellant's work as a sign language interpreter "did have a causal relationship to the pathology for which she underwent treatment." Dr. Pokabla reported that the position description clearly stated that she was required to work without breaks while interpreting for two to three hours at a time, also up to six hours with infrequent breaks. He explained that "this considerable overhead work would certainly place increased strain on the patient's shoulders."

Appellant provided a description of her position as an interpreter at the employing establishment. The summary regarding the physical demands of her job stated that the work "requires standing for long periods of time when interpreting (*e.g.*, two to three hours) without breaks and up to six hours with infrequent breaks." Training-related work was described as sedentary with no special physical demands required to perform the work. Appellant also provided a position description of her part-time job as a video relay service interpreter. The description stated that part-time employees worked up to 29 hours a week and that they determined their own schedules. Employees had a 15-second break between calls and calls varied in length from a few minutes to over an hour. Each employee may call for a team or pass off a call after the first 10 minutes of a call in order to change their pace.

Appellant also provided an article from the Registry of Interpreters for the Deaf regarding how interpreters could prevent and care for repetitive strain injuries. The article noted that the interpreters had a "high risk of developing some type of repetitive stress injury during their career." It further explained that because interpreters tended to hold their necks still while doing active repetitive movements this static motion wore down the pads between their cervical vertebrae which often led to compressed nerves, pain, stiffness, and numbness in their arms and hands.

By decision dated August 7, 2013, OWCP denied modification of the June 19, 2013 denial decision.

By letter dated and received on November 25, 2013, appellant, through counsel, requested reconsideration. Counsel alleged that appellant's claim should be accepted based on Dr. Pokabla's medical reports or at the minimum, that there was sufficient evidence to require additional medical development.

In a September 10, 2013 statement, appellant described the various functions of her sign language interpreting duties for the employing establishment. She stated that she may spend 30 minutes to an entire day interpreting depending on the function and that she had no other interpreter to relieve her. Appellant noted that even during her breaks she was often called to different areas in order to interpret something for a deaf or hard of hearing employee. She further stated that she also helped employees with personal or financial issues by interpreting for them. Appellant reported that during the rehabilitation from her first rotator cuff surgery her physician began to realize that it was the repetitive motion and the way she held her shoulders when she interpreted for long amounts of time that caused her injuries. Regarding her part-time job, she stated that each shift may consist of maybe four to five hours with a mandatory 10-minute break every hour. Appellant noted that the physical demands of her part-time job were nowhere as taxing as for the employing establishment.

In a November 15, 2013 letter, Dr. Pokabla stated that appellant was status post revision rotator cuff repair and arthroscopic biceps tenodesis. He noted that he reviewed her statements regarding both her federal and nonfederal jobs working as a sign language interpreter and concluded, to a reasonable medical certainty, that her diagnosis was directly related to her work duty as a federal sign language interpreter.

In a decision dated January 16, 2014, OWCP denied modification of the August 7, 2013 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim by the weight of the reliable, probative, and substantial evidence[3] including that he or she sustained an injury in the performance of duty and that any specific condition or disability for work for which he or she claims compensation is causally

[3] *J.P.*, 59 ECAB 178 (2007); *Joseph M. Whelan,* 20 ECAB 55, 58 (1968).

related to that employment injury.[4] In an occupational disease claim, appellant's burden requires submission of the following: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the employee.[5]

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.[6] The opinion of the physician must be based on a complete factual and medical background of the employee, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the employee.[7]

ANALYSIS

Appellant alleged that she developed bilateral elbow and shoulder conditions as a result of the repetitive use of her arms at or above shoulder height in the performance of her duties as a sign language interpreter. OWCP accepted that she worked as a sign language interpreter and was diagnosed with shoulder and elbow conditions. It denied appellant's claim finding insufficient medical evidence to establish that her diagnosed upper extremity conditions were causally related to her federal employment. The Board finds that this case is not in posture for decision as to whether appellant's bilateral upper extremity conditions resulted from factors of her federal employment.

As previously noted, an employee who claims benefits under FECA has the burden of establishing the essential elements of his or her claim.[8] As part of this burden, the employee must present rationalized medical opinion evidence, based upon a complete and accurate factual and medical background, establishing causal relationship.[9] However, it is well established that proceedings under FECA are not adversarial in nature, and while the employee has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence and to see that justice is done.[10]

[4] *M.M.,* Docket No. 08-1510 (issued November 25, 2010); *G.T.,* 59 ECAB 447 (2008); *Elaine Pendleton,* 40 ECAB 1143, 1145 (1989).

[5] *R.H.,* 59 ECAB 382 (2008); *Ernest St. Pierre,* 51 ECAB 623 (2000).

[6] *I.R.*, Docket No. 09-1229 (issued February 24, 2010); *D.I.*, 59 ECAB 158 (2007).

[7] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 465 (2005).

[8] *Supra* note 3.

[9] *Supra* note 7.

[10] *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

In support of her claim, appellant submitted various reports by Dr. Pokabla for treatment for right shoulder pain and symptoms beginning on December 30, 2009. He reviewed her history and noted that she worked as a sign language interpreter. Upon examination of her right shoulder, Dr. Pokabla observed decreased internal rotation when compared to the contralateral side and minor tenderness over the biceps tendon anteriorly. Neer's test was positive indicating impingement. Dr. Pokabla diagnosed right shoulder rotator cuff tendinitis/impingement. In May 5 and 24, 2010 reports, he related that appellant's right arm and shoulder were sore due to using her arm to sign for deaf people and that she complained of pain after interpreting for one and one half hours. In an August 31, 2012 report, Dr. Pokabla opined that appellant's "occupation as a signer for the deaf certainly put her shoulder at increased stress." In a July 5, 2013 report, he reviewed the medical treatment appellant received and noted that she underwent various surgeries, injections, and physical therapy. Dr. Pokabla noted that appellant spent a "significant amount of time with her shoulder in a forward flexion position holding her arm approximately at shoulder height." He opined that appellant's work as a sign language interpreter did have a causal relationship to the pathology for which she underwent treatment." In a November 15, 2013 report, Dr. Pokabla again concluded that after reviewing appellant's statements regarding both her federal and nonfederal jobs as a sign language interpreter, appellant's right shoulder rotator cuff and biceps tenodesis conditions were directly related to her work as a federal sign language interpreter.

The Board finds that while Dr. Pokabla's reports are not completely rationalized, they are consistent in indicating that appellant sustained an employment-related injury, and are not contradicted by any substantial medical or factual evidence of record. Dr. Pokabla accurately described appellant's medical history and work duties as a sign language interpreter. He provided findings on examination and provided a medical diagnosis of a right shoulder condition. Dr. Pokabla opined that appellant's right shoulder condition resulted from the repetitive duties of her federal employment. Although he did not provide a fully-rationalized medical opinion on causal relationship, Dr. Pokabla provided a consistent opinion based on examination findings and an accurate background that appellant's bilateral shoulder conditions were causally related to factors of her employment.[11] Therefore, while Dr. Pokabla's reports are not sufficient to meet appellant's burden of proof to establish her claim, they raise an uncontroverted inference between appellant's claimed condition and her federal employment, and are sufficient to require OWCP to further develop the medical evidence and the case record.[12]

OWCP found that Dr. Pokabla's opinion on causal relationship was not well rationalized because in the July 5, 2013 report he attributed appellant's bilateral shoulder condition to "overhead work." It determined that Dr. Pokabla did not accurately describe appellant's work factors as neither appellant's statements nor the description position mentioned "overhead work." OWCP concluded that Dr. Pokabla failed to properly explain any mechanism of injury for how appellant's interpreting duties resulted in her bilateral shoulder condition. The Board finds, however, that this one discrepancy in the July 5, 2013 report is insufficient to disprove or contradict Dr. Pokabla's previous reports which accurately describe appellant's employment

[11] *See D.G.*, Docket No. 14-901 (issued August 21, 2014).

[12] *Richard E. Simpson*, 55 ECAB 490, 500 (2004); *John J. Carlone*, 41 ECAB 354, 360 (1989).

duties. In the December 30, 2009 report, he stated that appellant had "head forward type posture" and attributed this condition to the fact that she worked as an interpreter which required her to have her "posture pulled forward." In January 24 and February 18, 2011 reports, Dr. Pokabla noted that appellant worked up to "10 hours a day with her shoulder in an elevated position." He also explained in a September 21, 2012 report that appellant needed to work limited duty with restrictions because signing required her to keep her arms elevated for long periods of time. Furthermore, the record clearly demonstrates in the July 5, 2013 report that Dr. Pokabla reviewed appellant's position description which stated that interpreters were required to interpret for two to three hours at a time without breaks and up to six hours with infrequent breaks. The Board notes that Dr. Pokabla consistently described appellant's sign language interpreting duties, specifically that she remained in a forward flexed position with her arms at shoulder height for a significant period of time, and that this description is supported by appellant's statements, the position description, and the article from the registry of interpreters for the deaf.[13] Dr. Pokabla also consistently opined that her interpreting duties caused or contributed to her bilateral shoulder conditions. Although his reports may not be fully-rationalized, they are sufficient to require OWCP to further develop the medical evidence and the case record.

The Board further finds that the additional medical reports of Dr. Weiss also support appellant's claim that she sustained a bilateral upper extremity condition as a result of her employment. In various reports dated January 11 to May 28, 2013, he noted that appellant was status post right shoulder arthroscopy with arthroscopic biceps tenodesis and left subacromial injection and injection of her bicipital groove. In a March 28, 2013 report, Dr. Weiss provided range of motion findings of appellant's shoulders and noted 4/5 motor strength. Supraspinatus stress and isolation tests were both negative. Dr. Weiss diagnosed status post right shoulder arthroscopy with biceps tenodesis. He stated that, due to the fact that appellant signed for a living, he did not think that she could return to that at this point due to the repetitive use of the arms. In a May 28, 2013 report, Dr. Weiss explained that he felt that what appellant was doing with her "repetitive use and work at shoulder level [had] aggravated or at least contributed to her shoulder condition that required surgery." He stated that she was authorized to return to light duty with restrictions of no overhead/repetitive use of the right upper extremity and no pushing, pulling, or lifting greater than 2 pounds. The Board finds that both Dr. Pokabla and Weiss's reports are consistent with appellant's statements and the position description to indicate that appellant's repetitive arm duties at shoulder height for an extended period of time as a sign language interpreter caused or contributed to appellant's bilateral upper extremity condition.

On remand, OWCP should prepare a statement of accepted facts and refer appellant to an appropriate medical specialist for a detailed opinion as to whether her bilateral upper extremity conditions are causally related to factors of her employment. Following this and any other further development as deemed necessary, it shall issue an appropriate merit decision on appellant's claim.

[13] The Board notes that this article is not regarded as medical evidence and has no evidentiary value in establishing a causal relationship between appellant's upper extremity conditions and her federal employment. *See Gloria McPherson*, 51 ECAB 441 (2000). It is only relevant to describe appellant's job duties and the physical stress attributed to the repetitive actions of sign language interpreters.

CONCLUSION

The Board finds that this case is not in posture for decision and requires additional development of the medical evidence by OWCP.

ORDER

IT IS HEREBY ORDERED THAT the January 16, 2014 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further development consistent with this decision of the Board.

Issued: January 26, 2015
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board